Psychosomatic Problems in Urology

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SUMMARY

The intimate relationship between the urinary and genital systems permits stimuli in one system to influence the other. At least 15 per cent of women with symptoms of cystitis have no organic basis for their complaints. In psychiatric studies it has been noted that sexual conflict is the primary etiological factor in these patients. In some cases, continuance of the disorder leads to irreversible organic change. Urinary symptoms such as frequency, urgency, burning or retention are most common in women and become an automatic response to anxiety-provoking or sexual stimuli.

In men, functional urinary symptoms are relatively infrequent. Often they indicate problems of genital dysfunction. Complaints of impotence, penile pain, testicular pain, or non-specific urethritis stem back to difficulties in their sexual lives. Many of the patients have symptoms of a generalized anxiety tension state due to sexual problems.

A purely organic consideration of genitourinary disorders will lead to erroneous conclusions and unsatisfactory therapeutic results. The psychosomatic approach—that is, considering both physical and psychological aspects—will explain many hitherto difficult cases.

IN recent years extensive studies have been made of the effects of emotional tension upon the skin, cardiovascular, respiratory and gastrointestinal systems, and the psychosomatic manifestations of disease of these systems and of other organs are now commonly recognized and treated from the psychiatric standpoint.[8] Emotional tension acting through the autonomic nervous system can affect the functioning of most organs. It is well known that many persons under acute emotional stress, such as that caused by taking examinations, may have urgency and frequency of urination, or even, on occasion, retention of urine. A tense person, chronically anxious, may respond to continuous strain by frequent urination, which may become a habit.

In view of this general knowledge, it is surprising how little can be found in the urologic and psychiatric literature on the interrelationship of the emotions and the urogenital system.[2, 3, 4, 6, 7] Observation of patients over the past eight years has convinced the authors that in cases in which urologic symptoms respond poorly to therapy for organic disease, there is associated emotional tension. If in careful examination organic disease is not found to be present, the psychological background of the patient should be explored. Consistently in such cases it has been noted that the patient has extreme reactivity to the stresses of everyday living. In none of the cases observed by the authors in which this situation existed did the patient have a satisfactory sexual life. Invariably, some emotional disturbance or frustration immediately preceded the onset of symptoms and each exacerbation occurred in similar circumstances.

While urination is a physiological process by which vesical tension is relieved, it also serves as a means of expressing certain psychological tensions and attitudes. The intimate histological and embryological connection between the urinary and genital systems permits physiological and psychological stimuli in one system to flow over and find discharge in the other. In the child, urination gives a feeling of pride and of physical satisfaction. Under certain stresses, an adult may revert to this action as a source of physical pleasure. In particular, some persons substitute urinary symptoms for sexual satisfaction when the latter is unobtainable. Some women retain urine for long periods because they experience a pleasurable sensation on voiding. When sexual arousal first appears in a child or adolescent, the unfamiliar feelings of tumescence and pelvic fullness are interpreted as stimuli from the bladder with a feeling of the need to urinate. Many adults have found that partial distention of the bladder enhances their erotic pleasure in sexual relations. Some persons, particularly women, owing to various conditioning experiences, have no direct sexual pleasure; in them it is displaced entirely to the urinary system. Almost all patients with urinary frequency and urgency for which no physical cause can be found are women, and almost all are sexually repressed or even frigid, their symptoms originating in situations of sexual frustration or temptation.

"CYSTITIS" IN WOMEN

"Cystitis" is a common disease in women. Among the symptoms are urgency, frequency, nocturia, and burning on urination. Of paramount importance in differential diagnosis is proper examination of the urine obtained by catheter. Absence of pus cells or bacteria in the urinary sediment indicates that vesical irritability may be due to nervousness. One-fourth of women with symptoms of cystitis have no urinary infection, and obviously chemotherapy will not re-

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lieve them. But about two-fifths of the patients of that order do have chronic urethritis which responds to vaginal stilbestrol suppositories. In the remaining three-fifths the symptoms of cystitis are psychogenic. In cystoscopic examination of patients in the latter group, increased redness of the trigone and urethra usually is noted, leading to a diagnosis of organic "trigonitis" and "urethritis." Occasionally hypertrophy of the detrusor muscle, secondary to sphincter spasm, is noted. Empirical treatment of these "inflammations" as organic disease consists of urethral dilatations, vesical irrigations and instillations of various antiseptic solutions and the endoscopic applications of such drugs as 10 per cent silver nitrate solution. In the authors' experience, response to this form of therapy is slow.

Embryologically, the urethra and trigone arise from cells which form the female generative tract. Hence the urethra and lower genital tract in the female not only have a common blood, lymph and nerve supply but are under the the same hormonal influence. Many women after prolonged love-making without copulation have low abdominal pain from the unrelieved congestion of the sexual organs, and frequency of urination may develop due to temporary vesical irritability. It is commonly observed that symptoms of "cystitis" are worse on the day after unsatisfactory intercourse and at the time of menses. Symptoms which should suggest the possibility of vesical irritability secondary to tension include frequency without nocturia, or intermittent frequency such as that occurring only in the morning or at bedtime.

In studying these patients it is frequently noted that the initial urinary symptoms came on abruptly after a sexually stimulating situation which for psychological reasons proved unsatisfactory. This appears particularly in cases in which the sexual feelings are repressed—that is, in which the patient is not consciously aware of erotic sensation. A frequent example is the sexually inexperienced or prudish young woman who becomes aware of pelvic fullness owing to sexual stimulus but interprets it as a need to urinate. By denying to herself that she has any arousal she displaces all sexual feelings to the urogenital system and establishes this pattern for tension discharge. It must be emphasized that this is an unconscious process; it is entirely beyond the patient's control and awareness. Once this mechanism is operative, sexual stimuli are responded to by urinary symptoms such as frequency or urgency, especially if sexual arousal is considered wrong. In several cases of married women, observed by the authors, the urological symptoms first appeared when the patients were on the way to or engaged in an extramarital affair.

CASE REPORT

A 27-year-old woman was referred because of complaints of urgency and frequency. Reared in a strict home, in fear of an alcoholic father, she was not permitted to have dates with boys. When 16 years old, the patient went on her first date without the consent of her parents. During the evening, she felt very tense due to fear of punishment and also the excitement of having her first boy friend. Sitting in a restaurant, she felt urgent need to void but was hesitant to ask to be excused. Suddenly she lost control and urinated, much to her shame and embarrassment. From then on she constantly feared a similar mishap. As a result of this constant tension, she felt a need to void frequently, sometimes as often as every hour, and would become panicky if no toilet were available. In marriage, she was unable to respond to sexual stimulation, and intercourse invariably culminated in distressing urgency and frequency. Menstruation also was accompanied by an increase of these symptoms. In recent years, she found that any disturbing situation accentuated the urinary difficulty.

No abnormality was noted in a urological examination. In a cystoscopic examination the urethra was observed to be normal but there was pronounced trabeculation of the bladder.

Under psychiatric treatment, the urgency and frequency diminished considerably as the patient understood the relation of these factors to her tension. Although the symptoms were much improved, there was some persistence because the need to void had become a habit and because organic changes had occurred in the bladder.

The case reported demonstrates how the initial urinary symptoms arise without any awareness of their true significance. The anxiety the patient felt in doing something wrong and the sexual stimulation when the patient was 16 years old were interpreted as a need to urinate. This established a pattern for reacting to subsequent erotic or anxiety-provoking stimuli with symptoms of frequency and urgency. Functional urological disorders of this kind occur most frequently in women. Men with this condition have comparable personality characteristics.

In studying patients with "cystitis" that does not respond to usual therapy, it is noteworthy that many of them unconsciously achieve feelings of erotic pleasure in the ministrations of a physician; manual or instrumental manipulation, particularly urethral dilatation or bladder irrigation, may be a distinct source of pleasure. A colleague reported that a 33-year-old unmarried woman under his psychiatric care was likely to have symptoms of cystitis when sexual outlets were unavailable. At such times, although the urine and the urinary tract were essentially normal, urgency and frequency continued until a course of bladder irrigations was carried out. Under psychiatric treatment, the patient recognized that the urological complaints were expressions of unsatisfied sexual needs.

OTHER PSYCHOLOGICAL FACTORS

Along with the erotic element present in urination, there is also a hostile or aggressive element. The not uncommon use of words or phrases referring to urination to express hostility in everyday language is indicative. Not infrequently noted in study of patients with urinary disorders are intense feelings of anger, often associated with the feelings of sexual deprivation, directed to the sexual partner. Many women with urinary symptoms have deep-seated hostilities toward men and dissatisfaction with their own femininity. In the case of a 35-year-

old woman, recently observed, all these elements were illustrated. The patient had been under some pressure from her mother and sister-in-law and was increasingly resentful. There had long been a struggle between the patient and her husband "to see which one had supremacy." She stated: "At this time my husband was top-dog and I wouldn't respond to him sexually. When I phoned for a psychiatric appointment and was told to wait a week I got mad, felt I was going to burst and found myself going to the toilet all day. From experience, I know that my urinary symptoms are not due to infection but to accumulated anger and frustration." When the patient was first observed, a burning sensation upon urination, and frequency and urgency were still present, but the symptoms rapidly cleared following discussion of the psychic factors responsible.

The functional disorders mentioned thus far are observed most often in women; not many men have functional cystitis. However, both men and women can have inhibition of the urinary stream under stressful situations. Some persons may have difficulty in voiding in public toilets. Usually, upon psychiatric study they are observed to be shy and retiring, unsure of themselves, and to have considerable sexual anxiety.

In cystometric studies carried out by Straub, Ripley and Wolf[6] it was observed that alterations of bladder function might be, in some instances, the only physical expression of emotional tension, or they might occur as part of a general psychophysiological reaction in association with other somatic disorders such as headache, backache, or menstrual irregularities. Pronounced increase in vesical tone could be produced by conversations touching on the patient's emotional problems. Bladder hyperfunction with urinary frequency was associated with a reaction of anxiety and resentment accompanying overt conflict. Bladder hypofunction with urinary retention was associated with emotional repression and withdrawal attitudes.

DISORDERS IN THE MALE

Impotence in its various forms of premature ejaculation, difficult erection, or lack of pleasure in intercourse is present in a very high percentage of the male population. The majority of men have had these difficulties at some period in their lives, and in many it persists through life. Kinsey[1] reported that more than 50 per cent of married men have some degree of premature ejaculation. Many men ejaculate within a few seconds of coital entrance or even before entering. Not everyone so affected seeks medical help. Many accept this sexual disability and go through life with no conscious concern. Others may be concerned and seek help to have it corrected. Many others attempt to deny the problem by a mechanism termed repression, and the anxieties express themselves in other symptoms, sometimes in testicular pain or penile pain, non-specific urethritis, or other dysfunctions of the genital system, but more often in symptoms of less obvious association such as headache, backache, gastric disturbance, and fatigue.

Impotence is rarely owing to organic disease. In most cases it is of psychic origin, nearly always the result of sexual fear.[2] Among the various kinds of sexual fear the commonest are fear of failure, fear of injuring the woman, fear of women, fear of consequences, fear of incest, fear of impregnating. In present-day culture, reaction to sex is mixed. On one hand are taboos on sexual curiosity and activity so that sexual matters are secret and surreptitious, and on the other a tendency to joke and deride. While masturbation is a normal phenomenon, society still considers it as bad, dirty or indecent. Every young man is disturbed by masturbation and nocturnal emissions until he somehow learns that they are quite normal. Other sexual activities which are now known to be biologically sound are anathematized as disgusting or abnormal. Even though sexual impulses are intensely strong in late adolescence and early adulthood, society rules that sexual activity be deferred until marriage so that sexual behavior at this time often is tinged with guilt. Prohibitions against and misinformation about biologically normal function set the stage for greater or lesser sexual difficulty at a later date.

Sexual fear may spring from less obvious roots. An overly affectionate mother will keep her son close to her and consciously or unconsciously try to prevent him from growing up and breaking away. The "silver cord" of novels is no mere figure of speech. A young man, consciously or unconsciously sensing his mother's clinging need, will feel guilt when he goes with girls, guilt that in greater or lesser measure influences his sexual ability. Even marriage does not solve this problem, since the maternal attachment is carried into the marriage; the man unconsciously sees his mother in his wife and fails sexually. The variations on this theme are infinite, but repeatedly the result is the same—some degree of sexual failure.

The growing child in the home where sex is considered nasty or wrong can hardly be expected to have a normal reaction when he reaches maturity. If the father is brutal or violent in action, the child considers sex an aggressive attack and in later years has the feeling that sexual activity is harmful to the woman.

A man who, as a young boy, became head of the family after the father's death—became the mother's husband in practically all respects save one—may have so deep a feeling of responsibility and attachment that he either cannot break away or, if he does marry, may be incapable of performing sexually as a husband.

Another common example is the man whose mother was the dominant force in the home and was contemptuous of or belittling of the husband. From this the young boy gets the impression that women are aggressive, destructive forces and a fear of women develops. As an adult, he, too, fails in sex relationships. (One patient, who was reared in a household ruled by a domineering mother, is com-

pletely impotent with his wife. He can have extramarital affairs without difficulty so long as he feels that he is in control of the situation. If the paramour of the moment becomes possessive or emotionally demanding, he becomes impotent.)

Fear of pregnancy may be present consciously or unconsciously in the male as well as in the female. In his children, a man may experience a continuation of the rivalry and jealousy he had for his brothers and sisters when he was a child.

Pain in the penis, urethra, prostate, testes, scrotum or perineum may be an expression of sexual anxiety. It is probable that in a careful history it will be noted that a patient with any of these symptoms is disturbed by premature ejaculation, by feelings of sexual temptation, or other expressions of sexual inhibition. Such a patient may attribute his failures to some organic defect and, by focusing attention there, stress any pain or discomfort in the genital area which might ordinarily have been transient. The penile or testicular ache is often the end result of sexual excitement occurring during sleep, culminating in erection and abruptly stopped, consciously or unconsciously, on the verge of orgasm.

Many men complain of persistent or recurring urethral discharge which, on microscopic examination, is found to contain no organisms and few, if any, pus cells. Such men generally are excessively sincere and conscientious with considerable guilt about real or fancied extramarital sexual affairs, if married, or sexual activity of any sort if unmarried.[5] If they indulge in any sexual act which they consider wrong, they have intense guilt, anxiety or even depression. They strive for continence, although consciously or unconsciously in a state of sexual excitation. The appearance of a urethral discharge, secondary to the prostatic congestion produced by sexual arousal, stirs up their guilt feelings. To treat this "urethritis" by somatic means is but to increase the feeling of guilt.

Most men with problems of sexual dysfunction have generalized nervous symptoms varying from anxiety tension states to neurasthenia. In dealing with a patient who has innumerable symptoms referred to many different organic systems with variable appearance and inconstant distribution, the possibility of anxiety neurosis should be considered. Careful questioning regarding details of his personal life, especially problems and worries in the sexual realm, will nearly always reveal highly pertinent material. In many cases increased redness of the trigone, prostatic urethra and verumontanum will be observed in cystoscopic examination. These changes are often interpreted as the causes of impotence rather than as the natural result of the sexual difficulties. This erroneous conclusion leads to organic therapy aimed at correcting the hyperemia. Unfortunately, not only are results unsatisfactory but guilt feelings are further increased, for the innocent patient is then convinced that the masturbation which he practiced in his adolescent years has caused severe damage to his sexual organs.

There is no question that some patients have been helped by testosterone, prostatic massage, instrumentation, or operative measures. Results, however, are inconstant. The administration of testosterone has strong suggestive power because the patient feels that a hormonal deficiency is being rectified. Many persons who have spectacular response to hormones do just as well on placebo pills so long as they believe them to be testosterone. The improvement associated with massage or other physical measures may also have a large psychic component. Guilt feelings due to masturbation or other forbidden sexual activity may be assuaged by the pain and discomfort of treatment which unconsciously are considered retributive punishment.

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